Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Aflibercept solution for injection for treating wet age-related macular degeneration.

Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Aflibercept solution for injection for treating wet age-related macular degeneration. London (UK): National Institute for Health and Care Excellence (NICE); 2013 Jul. 49 p. (Technology appraisal guidance; no. 294).

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

Aflibercept solution for injection is recommended as an option for treating wet age-related macular degeneration only if:

- It is used in accordance with the recommendations for ranibizumab in the National Institute for Health and Care Excellence (NICE) technology appraisal guidance 155, Ranibizumab and pegaptanib for the treatment of age-related macular degeneration (re-issued in May 2012) and
- The manufacturer provides aflibercept solution for injection with the discount agreed in the patient access scheme.

People currently receiving aflibercept solution for injection whose disease does not meet the criteria in the above recommendation should be able to continue treatment until they and their clinician consider it appropriate to stop.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Wet age-related macular degeneration

Guideline Category

Assessment of Therapeutic Effectiveness

Treatment

Clinical Specialty

Ophthalmology

Intended Users

Physicians

Guideline Objective(s)

To assess the clinical effectiveness and cost-effectiveness of aflibercept solution for injection for treating wet age-related macular degeneration

Target Population

Adults with wet age-related macular degeneration

Interventions and Practices Considered

Aflibercept solution for injection

Major Outcomes Considered

- Clinical effectiveness:
  - Visual acuity (the affected eye)
    - Gain or loss of visual acuity
    - Best corrected visual acuity
  - Visual acuity (the whole person)
  - Adverse effects of treatment
  - Health-related quality of life
  - Number of injections
  - Change in choroidal neovascularization (CNV)
  - Change in central foveal thickness
  - Fluid on optical coherence tomography
  - Adverse events
  - Morbidity and mortality rates
- Cost-effectiveness

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Care Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The Evidence Review Group (ERG) report for this technology appraisal was prepared by Aberdeen Health technology Assessment (HTA) Group (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Description of Manufacturer's Search Strategies and Critique

The manufacturer states that searches were undertaken in December 2011 and updated in June 2012. MEDLINE, MEDLINE-in-Process, MEDLINE Daily Update, EMBASE and the Cochrane Central Register of Controlled Trials were searched. Additionally, relevant conference proceedings from 2008 to 2012 were searched and clinical trial registers were consulted to identify ongoing studies. Full details of the search strategies are included in Appendix 2 of the manufacturer's submission and are reproducible.

The sources used for the identification of studies were appropriate and the search strategies were comprehensive, incorporating search filters where necessary. Controlled vocabularies and free text searching were used effectively and included a wide range of synonyms. The facets of the search (wet age-related macular degeneration; aflibercept, ranibizumab, bevacizumab; randomised controlled trials), and the synonyms within each facet, were combined correctly with Boolean operators. Overall, the search strategies were highly sensitive and fit for purpose.

Inclusion Criteria

The inclusion criteria used in the systematic review of clinical effectiveness are tabulated in Table 2 of the ERG report (see the "Availability of Companion Documents" field).

Cost-Effectiveness

The manufacturer economic evaluation of aflibercept for the treatment of wet age-related macular degeneration is based on a *de novo* economic model (Markov model) as none of the cost-effectiveness studies identified by the systematic literature review addressed the decision problem.

Number of Source Documents

Clinical Effectiveness

- Two relevant phase III randomised controlled trials (RCTs) of aflibercept vs ranibizumab
- 10 RCTs involving either ranibizumab or aflibercept, which were used to inform the network meta-analysis

Cost-Effectiveness

- No published studies addressed the decision problem
- The manufacturer submitted an economic model

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Meta-Analysis of Randomized Controlled Trials

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Care Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The Evidence Review Group (ERG) report for this technology appraisal was prepared by Aberdeen Health technology Assessment (HTA) Group (see the "Availability of Companion Documents" field).

Clinical Effectiveness

Quality Assessment

The manufacturer assessed the quality of all included studies: the two aflibercept randomised controlled trials (RCTs) and the 10 RCTs involving either ranibizumab or aflibercept, which informed the network meta-analysis. The methods used for quality assessment were considered adequate by the ERG.

The methodological quality of the VIEW 1 and VIEW 2 trials was good. Methods used to achieve randomisation were adequate and sequence allocation was concealed using a central interactive voice response system. Randomisation appears to have been successful, and there was not any imbalance between groups in terms of sociodemographic factors at baseline. All patients were masked (blind) to treatment status, and masking was maintained in the aflibercept 2 mg every 8 weeks (Q8) arm by giving sham injections on alternate months. The only study personnel unmasked to treatment status were those involved in the preparation and injection of the study drug. All personnel involved with outcome measurement and assessment were masked. The ERG considers the masking strategies of the VIEW trials appropriate. Although the manufacturer conducted per protocol analysis, the ERG does not consider that this is likely to increase the risk of bias as, for non-inferiority trials, use of the full analysis set is generally not considered to be conservative.

The quality of the other trials included in the indirect analysis was mixed. The report from the Kleijnen Systematic Reviews group, which accompanied the manufacturer's submission, highlighted particular concern with the CATT, DETAIL and MOON trials. The ERG shares this concern over the potential risk of bias of these trials.

The ERG performed a quality assessment of the manufacturer's systematic review using the York Centre for Reviews and Dissemination (CRD) criteria (see Table 4 of the ERG report). The quality of the systematic review was good, and the ERG has no major concerns in any of the quality areas.

Meta-Analysis

No meta-analysis of the VIEW 1 and VIEW 2 trials was presented by the manufacturer in their submission. They stated that this was because the two trials were similarly designed so that their data could be pooled directly. The meta-analysis of VIEW 1 and VIEW 2 was, however, presented within the Kleijnen systematic review.

Indirect Comparison – Summary of Results

The treatment regimen for ranibizumab used in VIEW 1 and VIEW 2 was fixed dose but the manufacturer states that in clinical practice a 'treat to target' approach is used. This involves monthly treatment until the patient's visual acuity (VA) is stable for 3 consecutive months, with re-treatment in a similar way upon loss of VA (with minimum of 2 injections). Therefore the manufacturer commissioned a systematic review by Kleijnen Systematic Reviews group (included in the reference pack of the current submission) to identify studies which included this alternative and then undertook an indirect comparison of the data to compare fixed dose aflibercept (AFB 2 mg Q8) compared with ranibizumab 0.5 mg in a 'reactive dosing' or 'treat as needed' regimen. This type of dosing is referred to as 'pro re nata' (PRN).

The Kleijnen Systematic Reviews group produced three networks for consideration: at 6, 12, and 24 months. However, as no trials reported aflibercept results at 6 months, this network is not discussed further. Figures 1 and 2 of the ERG report display the networks for 12 months and 24 months, respectively.

The Kleijnen Systematic Reviews group undertook three types of indirect comparison: simple Bucher analysis, frequentist network analysis (using STATA) and Bayesian network analysis (using WinBUGS) and the results are now summarised.

See Section 4 of the ERG report for more information on the Kleijnen Systematic Reviews group report, and additional work carried out by ERG.

Cost-effectiveness

Summary and Critique of Manufacturer's Submitted Economic Evaluation by the ERG

The manufacturer economic evaluation of aflibercept for the treatment of wet age-related macular degeneration is based on a *de novo* economic model (Markov model) as none of the cost-effectiveness studies identified by the systematic literature review addressed the decision problem. The *de novo* economic model developed by the manufacturer is a two-eye model based on the appraisal scope.

See Section 5.2, "NICE Reference Case Checklist," in the ERG report (see the "Availability of Companion Documents" field).

Model Structure

The model structure is best thought of as a one eye model, with the facility for the development of 2nd eye involvement and the application of some costs and benefits to any 2nd eye involvement. Because of this, the one eye model will be described in detail followed by a description of the modelling of 2nd eye involvement. The ERG has major concerns about the modelling of 2nd eye involvement.

Visual acuity is banded into five health states, with these mostly being 15 letters wide, with the additional health state of death. See Table 23 of the ERG report for visual acuity bands within the model.

Patients begin the model with wet age-related macular degeneration in their 1st eye, and it is assumed that there is no wet age-related macular degeneration and no visual impairment (NVI) in their 2nd eye.

The baseline distribution between the visual acuity bands for the 1st eye is taken from the screening visit of the aflibercept arm of the VIEW 2 trial.

To model the aflibercept arm for year 1, the proportions of patients:

- Gaining more than 30 letters
- Gaining 15 to 30 letters
- Remaining within 15 letters
- Losing 15 to 30 letters
- Losing more than 30 letters

Between baseline and year 1 are applied to the baseline patient distribution, with the assumption that these proportions apply equally to each health state. To model the aflibercept arm for year 2, the proportions of patients gaining and losing letters between year 1 and year 2 are applied to the estimated patient distribution at year 1. As these are last observation carried forward (LOCF) distributions a proportion of patients are modelled as discontinuing and moving onto best supportive care (BSC) and a proportion of patients are modelled as dying.

The modelling of ranibizumab PRN in year 1 and year 2 follows the same logic, only with the year 1 proportions gaining letters for aflibercept being conditioned by the relative risk of gaining letters to provide estimates for ranibizumab, and the proportion remaining stable being similarly conditioned by the relative risk of maintaining letters. These relative risks are drawn from the Kleijnen systematic review 12 month analyses. The year 1 to year 2 proportions gaining letters and maintaining letters for aflibercept are also conditioned by relative risks, these relative risks are drawn from the Kleijnen systematic review 24 month analyses.

For years 3 to 5 patients are assumed to remain on treatment and have stable visual acuity. But patients on treatment may exit the one eye on treatment model to BSC due to discontinuations. From the start of the third year patients may also develop 2nd eye involvement. From year 6 all patients are assumed to cease treatment and move onto BSC. BSC is associated with a steady loss of visual acuity over time.

Sensitivity Analyses

A range of univariate sensitivity analyses were presented around resource use, coupled with two sensitivity analyses around the relative risk of improving vision in year 1 and the relative risk of maintaining vision in year 2.

It may have been more sensible to have performed the sensitivity analyses varying the proportion receiving therapy in one stop clinics across all 5 years of treatment, rather than varying it for individual years.

Model Validation and Face Validity Check

Model validation is limited to comparing the modelled distribution of visual acuity for the study eye for the aflibercept 2 mg Q8 arm with the trial data at baseline, 52 weeks and 96 weeks. The manufacturer response to ERG clarification questions provides the distributions of the treated eyes within the trials, though note that this reporting has switched to the Safety Analysis Set.

See Section 5 of the ERG report (see the "Availability of Companion Documents" field) for more information on cost-effectiveness analysis.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Considerations

Technology appraisal recommendations are based on a review of clinical and economic evidence.

Technology Appraisal Process

The National Institute for Health and Care Excellence (NICE) invites "consultee" and "commentator" organisations to take part in the appraisal process. Consultee organisations include national groups representing patients and carers, the bodies representing health professionals, and the manufacturers of the technology under review. Consultees are invited to submit evidence during the appraisal and to comment on the appraisal documents.

Commentator organisations include manufacturers of the products with which the technology is being compared, the National Health Service (NHS) Quality Improvement Scotland and research groups working in the area. They can comment on the evidence and other documents but are not asked to submit evidence themselves.

NICE then commissions an independent academic centre to review published evidence on the technology and prepare an "assessment report". Consultees and commentators are invited to comment on the report. The assessment report and the comments on it are then drawn together in a document called the evaluation report.

An independent Appraisal Committee then considers the evaluation report. It holds a meeting where it hears direct, spoken evidence from nominated clinical experts, patients and carers. The Committee uses all the evidence to make its first recommendations, in a document called the "appraisal consultation document" (ACD). NICE sends all the consultees and commentators a copy of this document and posts it on the NICE Web site. Further comments are invited from everyone taking part.

When the Committee meets again it considers any comments submitted on the ACD; then it prepares its final recommendations in a document called the "final appraisal determination" (FAD). This is submitted to NICE for approval.

Consultees have a chance to appeal against the final recommendations in the FAD. If there are no appeals, the final recommendations become the basis of the guidance that NICE issues.

Who Is on the Appraisal Committee?

NICE technology appraisal recommendations are prepared by an independent committee. This includes health professionals working in the NHS and people who are familiar with the issues affecting patients and carers. Although the Appraisal Committee seeks the views of organisations representing health professionals, patients, carers, manufacturers and government, its advice is independent of any vested interests.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

Summary of Appraisal Committee's Key Conclusions on Cost-Effectiveness

Availability and Nature of Evidence

The Committee considered the manufacturer's economic model and the Evidence Review Group's (ERG's) critique and exploratory analyses. The Committee agreed with the ERG that it was unrealistic to assume no second-eye involvement in the first 2 years of the model because a large proportion of patients in the VIEW 1 and 2 trials had visual impairment in their second eye at the start of treatment. The Committee concluded that the ERG's exploratory approach, which involved separate analyses depending on whether the study eye was a better-seeing eye or worse-seeing eye, was more reasonable.

Uncertainties Around and Plausibility of Assumptions and Inputs in the Economic Model

The Committee noted the ERG's comments that the manufacturer had applied comparative clinical effectiveness data in terms of visual acuity from its network meta-analyses and indirect comparisons between baseline and 12 months and between 12 months and 24 months rather than between baseline and 12 months and between baseline and 24 months. The Committee agreed with the ERG that the results of the manufacturer's indirect comparison at 24 months provided comparative clinical-effectiveness data between baseline and 24 months, and it concluded that the ERG's exploratory analysis that incorporated this data was the preferred approach.

The Committee concluded that it was reasonable to assume that people in both treatment groups would need 8 treatment visits in the first year of the model in line with the approach taken by the ERG in its exploratory analyses.

The Committee concluded that, based on current clinical practice, it was reasonable to assume that 50% of people in both treatment groups would need separate monitoring visits in line with the approach taken by the ERG in its exploratory analyses.

The Committee concluded that although some uncertainty remained about the true costs involved in treatment and monitoring visits for people with wet age-related macular degeneration, the estimates used in the ERG's exploratory analyses were a fair reflection of the costs involved.

Incorporation of Health-Related Quality-of-Life Benefits and Utility Values/Have Any Potential Significant and Substantial Health-Related Benefits Been Identified That Were Not Included in the Economic Model, and How Have They Been Considered?

No specific conclusions were made by the Committee about health-related quality-of-life benefits and utility values.

Are There Specific Groups of People for Whom the Technology Is Particularly Cost-Effective?

None was identified.

What Are the Key Drivers of Cost-Effectiveness?

The results of the manufacturer's one-way sensitivity analyses indicated that the cost effectiveness of aflibercept was most sensitive to the drug acquisition costs, frequency of injections and monitoring visits, proportion of people in 1-stop and 2-stop models, discount rates and the relative risk of gaining or losing visual acuity with ranibizumab treatment.

Most Likely Cost-Effectiveness Estimate (Given as an Incremental Cost-Effectiveness Ratio [ICER])

The Committee noted that its preferred analyses incorporated the confidential discount to the list price of aflibercept and a range of discounts (from 0 to 50%) to the list price of ranibizumab. It also noted that, when discounts to the list price of ranibizumab ranged from 0 to 45%, aflibercept had lower costs and quality-adjusted life years (QALYs) than ranibizumab, which resulted in ICERs for aflibercept compared with ranibizumab ranging from £1,690,000 to £16,700 saved per QALY lost and that, when a 50% discount was applied to the list price of ranibizumab, aflibercept was dominated by ranibizumab in both the worse-seeing eye and better-seeing eye models. However, the Committee was aware that, in both the manufacturer's and the ERG's analyses, the differences in total costs and QALYs were very small.

Method of Guideline Validation

External Peer Review

Description of Method of Guideline Validation

Consultee organisations from the following groups were invited to comment on the draft scope, assessment report and the appraisal consultation document (ACD) and were provided with the opportunity to appeal against the final appraisal determination.

- Manufacturer/sponsors

- Professional/specialist and patient/carer groups
- Commentator organisations (without the right of appeal)

In addition, individuals selected from clinical expert and patient advocate nominations from the professional/specialist and patient/carer groups were also invited to comment on the ACD.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated for each recommendation.

The Appraisal Committee considered clinical and cost-effectiveness evidence and a review of this submission by the Evidence Review Group.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate use of aflibercept solution for injection for treating wet age-related macular degeneration

Potential Harms

The summary of product characteristics lists the following most common adverse reactions for aflibercept solution for injection: conjunctival haemorrhage, eye pain, vitreous detachment, cataract, vitreous floaters and increased intraocular pressure.

For full details of adverse reactions and contraindications, see the summary of product characteristics available at http://emc.medicines.org.uk/ .

Qualifying Statements

Qualifying Statements

- This guidance represents the views of the National Institute for Health and Care Excellence (NICE) and was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.
- Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Implementation of the Guideline

Description of Implementation Strategy

- Section 7(6) of the National Institute for Health and Care Excellence (NICE) (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 requires clinical commissioning groups, National Health Services (NHS) England and,

with respect to their public health functions, local authorities to comply with the recommendations in this appraisal within 3 months of its date of publication.

- When NICE recommends a treatment "as an option", the NHS must make sure it is available within the period set out in the paragraph above. This means that, if a patient has wet age-related macular degeneration and the doctor responsible for their care thinks that aflibercept solution for injection is the right treatment, it should be available for use, in line with NICE's recommendations.
- The Department of Health and the manufacturer have agreed that aflibercept solution for injection will be available to the NHS with a patient access scheme which makes aflibercept solution for injection available with a discount. The size of the discount is commercial in confidence. It is the responsibility of the manufacturer to communicate details of the discount to the relevant NHS organisations. Any enquiries from NHS organisations about the patient access scheme should be directed to lesley.gilmour@bayer.com.
- NICE has developed tools to help organisations put this guidance into practice (listed below). These are available on the NICE Web site (http://guidance.nice.org.uk/TA294).
    - Costing template and report to estimate the national and local savings and costs associated with implementation.

Implementation Tools

Audit Criteria/Indicators

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

National Institute for Health and Care Excellence (NICE). Aflibercept solution for injection for treating wet age-related macular degeneration. London (UK): National Institute for Health and Care Excellence (NICE); 2013 Jul. 49 p. (Technology appraisal guidance; no. 294).

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2013 Jul

Guideline Developer(s)

National Institute for Health and Care Excellence (NICE) - National Government Agency [Non-U.S.]

Source(s) of Funding

National Institute for Health and Care Excellence (NICE)

Guideline Committee

Appraisal Committee

Composition of Group That Authored the Guideline

Committee Members: Professor Andrew Stevens, Chair of Appraisal Committee C, Professor of Public Health, University of Birmingham; Professor Gary McVeigh, Vice Chair of Appraisal Committee C, Professor of Cardiovascular Medicine, Queens University Belfast and Consultant Physician, Belfast City Hospital; Professor Kathryn Abe, Director of Centre for Women's Mental Health, University of Manchester; Dr Daniele Bryden, Consultant in Intensive Care Medicine and Anaesthesia, Sheffield Teaching Hospitals NHS Trust; Dr Andrew Burnett, Director for Health Improvement and Medical Director, NHS Barnet, London; David Chandler, Lay Member; Gail Coster, Advanced Practice Sonographer, Mid Yorkshire Hospitals NHS Trust; Professor Peter Crome, Honorary Professor, Dept of Primary Care and Population Health, University College London; Dr Maria Dyban, General Practitioner, Kings Road Surgery, Glasgow; Professor Rachel A Elliott, Lord Trent Professor of Medicines and Health, University of Nottingham; Dr Greg Fell, Consultant in Public Health, Bradford Metropolitan Borough Council; Dr Peter Jackson, Clinical Pharmacologist, University of Sheffield; Dr Janice Kohler, Senior Lecturer and Consultant in Paediatric Oncology, Southampton University Hospital Trust; Emily Lam, Lay Member; Dr Allyson Lipp, Principal Lecturer, University of Glamorgan; Dr Claire McKenna, Research Fellow in Health Economics, University of York; Dr Grant Maclaine, Director, Health Economics and Outcomes Research, BD, Oxford; Dr Andrea Manca, Health Economist and Senior Research Fellow, University of York; Henry Marsh, Consultant Neurosurgeon, St George's Hospital, London; Dr Suzanne Martin, Reader in Health Sciences; Dr Paul Miller, Director, Payer Evidence, Astra-Zeneca UK Ltd; Professor Eugene Milne, Deputy Regional Director of Public Health, North East Strategic Health Authority, Newcastle upon Tyne; Professor Stephen O'Brien, Professor of Haematology, Newcastle University; Dr Anna O'Neill, Deputy Head of Nursing and Healthcare School/Senior Clinical University Teacher, University of Glasgow; Alan Rigby, Academic Reader, University of Hull; Dr Peter Selby, Consultant Physician, Central Manchester University Hospitals NHS Foundation Trust; Professor Matt Stevenson, Technical Director, School of Health and Related Research, University of Sheffield; Dr Tim Stokes, Senior Clinical Lecturer, University of Birmingham; Dr Paul Tappenden, Reader in Health Economic Modelling, School of Health and Related Research, University of Sheffield; Dr Judith Wardle, Lay Member

Financial Disclosures/Conflicts of Interest

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the National Institute for Health and Care Excellence (NICE) Web site .

Availability of Companion Documents

The following are available:

- Cummins E, Fielding S, Johnston R, Rothnie K, Stewart F, Lois N, Burr J, Brazzelli M. Aflibercept solution for injection for the treatment of wet age-related macular degeneration: a single technology appraisal. Aberdeen (Scotland): Aberdeen Health Technology Assessment (HTA) Group; 2013 Mar. 101 p. Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Care Excellence (NICE) Web site .
- Wet age-related macular degeneration. Clinical audit tool. London (UK): National Institute for Health and Care Excellence (NICE); 2013 Sep. Various p. (Technology appraisal guidance; no. 294). Electronic copies: Available from the NICE Web site .
- Aflibercept solution for injection for the treatment of wet age-related macular degeneration. Costing template. London (UK): National Institute for Health and Care Excellence (NICE); 2013 Jul. Various p. (Technology appraisal guidance; no. 294). Electronic copies: Available from the NICE Web site .

Patient Resources

The following is available:

- Aflibercept injection for treating wet age-related degeneration. Information for the public. London (UK): National Institute for Health and Care Excellence (NICE); 2013 Jul. 6 p. (Technology appraisal guidance; no. 294). Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Health and Care Excellence (NICE) Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

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